

Idiomorphism: the Lost Continent

How diagnosis displaces personal understanding

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Humans are both eternally blessed and cursed by individual uniqueness, memory and imagination: for while these constitute the richness of our lives, they also generate our 'mental disorder'. To successfully address or remedy most of our human dis-ease we need, therefore, to understand each person's *unique* meaning and context of presentation. This is a conundrum, for all systems, diagnoses, nosologies and taxonomies operate by eliminating such notions: they are instead based on observation of *commonality*. Our culture is increasingly in thrall to such eliminations. What happens?

Introduction and summary

In understanding of the non-human world, our scientific procedures and 'objective' observation and generic clustering serve us well. But human complexity renders such presumptions much less reliable: motivation, protean states of (un)consciousness, encoded behaviours and communications, concealed diversities – all such phantoms are signifiers of the human condition; and all are frequently elusive and impenetrable to our usual scientific endeavours.

Publicly provisioned healthcare is now largely designed and guided by a new cultural convention: 'Evidence Basis'. This is anchored to science whose competence is rooted in the impersonal. While this often works well in dealing with clear physical disease – 'structural pathology' – it becomes adversely inadequate with other kinds of distress. It is these 'functional disturbances' – dis-ease – that comprise the subtlest challenges to healthcare. Our understanding and response to this world of human complexity, paradox and chimera needs very different, though complementary, skills. The illustrating vignettes in this article are authentic and typify what is common in primary care. In psychiatry and psychology it is the subterranean, though now increasingly, and hazardously, disregarded.

How do we respond?

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‘Though all men be made of one metal, yet they be not cast all in one mould’

John Lyly Euphus, *The Anatomy of Light* (1579)

‘Every man is more than just himself: he also represents the unique, the very special and always significant and remarkable point at which the world’s phenomena intersect, only once in this way and never again.’

Herman Hesse, *Prologue to Demian* (1979)

A. Idiomorphism – People’s stories. Samples from primary care. End: Week 1

1. Cathy

Age 63, Cathy has suddenly looked older, since she found her husband, Bob, collapsed and dead in the bathroom. A stalwart and uncomplaining man, his life suddenly ended; a mortality shocking for its lack of warning. The coroner had judged it due to a massive heart attack.

Dr R had had only light and infrequent, though amiable, contact with Bob over many years. Cathy’s many encounters with her doctor had been very different. Twelve years ago she had discovered Bob in a secret, flirtatious tryst with a younger woman. Theirs was a long marriage, blighted by infertility; for decades they compensated with affectionate care and companionship. Until this quaking portent of infidelity and abandonment.

Cathy had responded with a primitive and punitive maelstrom of explicit and encoded emotion. Fear, grief, rage, despair all fed into her abject and retributive broth of distress of body and mind. How could either she, or he, be motivated or permitted to go on living in the wake of such betrayal? Earlier Dr R had feared explosive or implosive catastrophe. After six years he felt safer; like a clergyman suggesting, nurturing and guiding buds of forgiveness. Cathy now sustained a warily melancholic marital bond with Bob: ‘I love him but I won’t tell him, or allow him too close ... he has to sleep on the sofa, doctor’.

Two days after she finds his just-deceased body, warm but unbelievably still on the bathroom floor, she seeks out Dr R. She is ushered in, kindly, by the receptionist as an end-of-surgery ‘Emergency’. She is almost mute with shocked intensity, choked

and blinded with tears. Dr R knows he cannot hurry – he has to lean far forward to hear her barely expressed voice: ‘ I thought I heard a “crump” but I wasn’t sure ... I waited a minute, then went in and found him ... I think I could have saved him, if I’d gone immediately ... So it’s my fault: if it weren’t for me, he’d be alive ... I don’t think I can live without him ... Does he know that, doctor? ... Do you?’.

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2. Amir

When Amir first came, he could not talk of his hurts, his shame, his well of sadness, his furnace of fury. Only slowly has Dr R understood the exhausting struggle Amir has to endure and bear alone. Amir is a large-framed, but compliant and placatory man. His story, which Dr R has always believed, was largely made and smashed by others. His arranged marriage in India, to Kalpur, twenty years ago, had been largely fertilised and conceived by their two prominent and dominant families in a small Kashmiri town. After their arrival in London fifteen years ago, Amir had felt blessed with Kalpur, their new country and the birth of three daughters. Social and biological fate seemed to be gently smiling on them all.

Back in Kashmir, destructive troubles were hatching that he was not party to, did not understand and could never influence. Like a terrible storm, these troubles would quickly devastate his life’s achievements and plans. In the North of Kashmir their two families had fallen into a primitive and internecine feud. Kalpur, perplexedly paralysed and then controlled by the most commanding gravitational force, turned on, then ejected her husband from the family group.

When he first came to see Dr R, his distress was so raw, intense and beyond his usual vocabulary, that he could hardly speak. His demeanour told Dr R much more: his sagged, leaden gait; tearful eyes, avoiding contact, yet conveying fear and shame; a voice defeated, yet still apologetic; smart clothes, now crumpled.

From this fragile and inchoate tangle Dr R had to be delicate and patient in constructing a story – Amir’s ‘History’ – explaining not only his immediate symptoms – his dis-ease – but also his massive losses: of marriage, fatherhood, family, home and occupation – his alienation.

After Amir's faltering and pained initial meeting with Dr R, the doctor had thought Amir's risk and distress were so high he should see a psychiatrist urgently. This was arranged with seamless rapidity. The assigned contact was more problematic: Amir later said 'they [the Psychiatric Team] just kept asking all these questions about "voices", and whether I really wanted to kill myself ... so much, so many questions! ... I couldn't really speak, or even think...' Amir refused to return to them.

Dr R thought of the old term for psychiatrist – 'Alienist' – and how this connoted a practitioner skilled in the art of healing torn or withered connections – with one's Self, Others, the world around. Dr R thought that these current Alienists were themselves alienated, at least from Amir and *his* alienation.

About a year later Amir gazes at Dr R, now with warmth, sorrow, calmness and deliberation. 'If you hadn't understood me or my situation then I wouldn't be alive now', he says with quiet, economic gratitude. Dr R experiences some glow of satisfaction. It is shared evidence, and private recognition, of his piloting such tempestuous seas. But he is also disquieted; harried by a wider concern: if he had not undertaken this, who would?

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3. Clare

Clare was tormented, feared she could not understand her feelings, nor be understood. 'Am I going mad, doctor?...' Twelve years ago, her relationship with Danny had finished with ugly and menacing cacophony, leaving her alone with two small sons. Danny had always been demanding and jealous of her attention, and could not accept his new role of father, with all its compromises and deferred gratifications. Danny's second act of drunken violence decided Clare's finishing their relationship, though not her yearning or grief. After a dangerous and tangled period of threats, court appearances and injunctions, Danny retreated. Clare was left to complete the long and lonely voyage of single motherhood. Danny has not been seen for years.

Clare has heard that Danny is in prison, for another violent crime. Her sons, Sean, 15, and Craig, 17, have also heard. She has been having problems with Craig's increasing adolescent anger and intimidation; now it is worse: 'Craig's now very tall: taller than Danny ... he gets so angry, I often think he's possessed by some kind of demon ... he stands over me, his voice so loud and hard: the worst thing is that he sounds and looks to me just like Danny, all those years ago ... My feelings are so mixed-up: I become really scared, and at the same time often hate Craig, for being so like Danny ... I feel resentful and then so guilty ... How can I feel these things, as his mother? ... Can you understand all this, doctor?'

Dr R thinks this is a rhetorical question, for which she is seeking his reassurance and validation: she would not have entrusted him with 'all this' if she felt he had not understood. Dr R muses on understanding this understanding: how it has arisen from years of unstructured and unscheduled contacts, each adding to a growing bond of trusting familiarity, each enabling thoughts to be clarified, feelings to be verbalised, connections to be seen. Like a gardener, he could not use his skills to command these processes; only encourage, protect and nourish what might emerge.

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4. Alf

Alf carries his 82-year-old, tall frame with remarkable uprightness, discipline and pride. He has been wearing a similar brass-buttoned navy-blue blazer since Dr R first met him in the 1970s, but it never looks worn. Despite this mien of well-kempt fortitude, Alf now looks pale and unwell. He crosses the room with slow, frail caution. As he sits down Dr R is struck by the depleted timbre of his voice, the deadness of his gaze. Alf had come with such heralding signs of depression many times and years before when, at least, his physical health was then robust.

Dr R had also known Alf's brothers. All four had a similar manner of intelligent, diligent courtesy. All had followed their father's occupation in the London Docks. Remarkably, all had remained unmarried and, at some time, all had been treated at the old Victorian Mental Hospital. Dr R can remember mechanically-typed letters from the 1960s, documenting how all (and the deceased father, and father's father, and father's brother) had suffered from 'Periodic Familial Melancholia', later

'Recurrent Endogenous Depression'. Dr R had been encouraged by how their afflictions became more manageable as the medications had improved. A fascinatingly clear constellation illustrating 'biological psychiatry', Dr R had said several times to his students.

Despite his current bleakness, it seems important for Alf to have this contact with Dr R:

'My life seems so empty, so meaningless ... My brothers have all died and now I have no family at all ... My Chinese neighbour doesn't speak English, or even know my name ... Now I've got prostate cancer, I've never felt so alone: you're now the only person that's known me, from all those years ago ...'

He pulls himself up in his chair, his voice a little stronger:

'All my usual symptoms have come back, really badly. So, I remembered what you said last time, and yesterday increased my [antidepressant] tablets. I know there's nothing else for you to do, doctor, but I just thought you'd want to know ... Shall I come back in a fortnight, so you can see how I am ...?'

Alf, like his brothers, has never obstructed more personal exploration, though never benefited from such efforts either. Dr R has little to do but be mindful and respectful of the subtext. He ponders how apparently simple is his task, yet how important it is for Alf. Any attempt to diminish or delete this humble but subtle role would, very likely, have tragic consequences. The paradoxical skill lies in recognising the complexity of the simple.

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5. Tom

Tom's normally aquiline, handsome features are shockingly obscured. His left eye is almost closed by grey and purple swelling. Above it a normally elegantly arched eyebrow has been torn, now stitched and encrusted by dried blood. A domed grey-brown bruise on his left forehead sits astride this ugly asymmetry.

Tom is unable to offer his usual playful smile to Dr R: he is hurt and hurting. 'I was Gay-Bashed ... they came from behind, four of them, maybe five: I couldn't see and didn't stand a chance ... I know who they are. The Police want my injuries recorded, and I just wanted to tell you anyway...'

A year ago Tom had come with a less visible but equally distressing pain. His father had died very rapidly from an unsuspected but evidently virulent malignancy. Tom had never had a satisfactory bond with his father: he had experienced him as critical, harsh and controlling. Tom's mother was lovingly collusive with Tom about his homosexuality, but it was never openly acknowledged with father: an unexploded bomb.

Tom, now mid-thirties, has built himself a stable and positive life: good friends, a loving partner and a meticulously orderly occupation as an Air Traffic Controller. But there is a painful gap where there was no loving father: his grief is not for the father he lost, rather the father he never had. Dr R, during Tom's fresh grief, had talked with him a few times of such things, helping him through this raw ravine. Dr R was aware of his likely role, as an older man: the father who listens, includes, accepts. The father Tom never had. Dr R thought Tom clearly realised this, though they spoke of it only lightly and elliptically.

Tom's bruised humiliation seems lightened by Dr R's inspection, witness and then suggestion that he returns in a week 'to see how things are settling'. Dr R thinks that Tom understands the meaning of this connecting and containing healing ritual.

'Thanks, Doc: you're a rock!', he says with a brave lopsided smile and an offer of affectionate banter.

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As Dr R finished his Friday evening surgery, he thinks of Cathy, Amir, Clare, Alf and Tom – and others, too, he has seen that day – each a mixture of the universal and the unique. For each struggles for personal connection, meaning, definition, safety, comfort, recognition or belonging. Lost or foundering in the struggle, each may be diagnosed as having 'Anxiety' or 'Depression' – these are easily packaged:

elementary clusters in an inevitably crude science of distress. Yet it is perceiving the uniqueness of each individual and each consultation that has most sustained, for many years, Dr R's interest, engagement and Élan Vital. This is the Art and, Dr R has long thought, the heart of healing. Here, in this fragile, often elusive but powerful space within and between persons, is where compassionately imaginative contact can grow its most prized fruit.

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B. The Generic – Cluster, convention and code. Start: Week 2

It is late Monday morning and Dr R has cleared the rest of the day to attend a large professional area meeting: Plans for Commissioning Mental Health Services. Before he goes, he steels himself to read another administrative obelisk: a lengthy and didactic diktat from the National Institute of Clinical Excellence (NICE): 'The Management of Anxiety and Mood Disorders'. The format is familiar: first the awakening warning of how large is the problem and its cost in personal, financial and organisational terms; then the complex problem is broken down into functional or administrative subcomponents; finally each is delegated or despatched, via serial towers of bullet points and forests of algorithms. Implicitly it is only the parts that matter; the whole becomes an irrelevant abstraction. Dr R, heeding some internal voice of higher authority, deflects his own objections and instead disciplines his attention until the end of this document of instruction. As he does so he feels his mind constrict, his energy deplete. An unbidden childhood memory comes into his mind: an image of a Primate confined to a small bare cage in a city zoo.

What will this afternoon's meeting bring?

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Dr S is addressing the serried ranks of higher echelon healthcare workers. His manner is courteous, amiable but commanding: a public school headmaster pep-talking his staff. He makes clear how important it is that clear diagnoses are made, so that the correct care-pathways can be followed. This can be done by filling in relevant questionnaires and algorithms that clarify, validate and quantify diagnosis:

the nature and severity of the complaint thus becomes defined precisely. This yields a clear path – necessary not just for more scientific research, but also more effective treatment and then commodification. Commissioning will be expedited: more funding can be garnered. Thus, increasingly, mental illnesses will be diagnosed, containerised, despatched, streamed, managed and marketed: like procedures in physical illness now, in the new NHS economy.

The audience looks, Dr R thinks, mostly acquiescent, but not engaged: semi-slumped to obediently receive these new notions of authority. Dr R is thinking how these devices of cluster, convention and code are predicated on generic similarities, but become inimical to his personal understanding. They help him little with the complex dances he must improvise to help others find courage, heal and grow. How do we address such limitless human complexity and variation with sense and sensibility; to accurately understand each person and their maybe-similar-but-always-unique difficulties? The *Generic* is the accessible territory for planners, statisticians, economist and managers: but it is the *Idiomorphic* that often most helpfully guides the practitioner – to make personal sense with *this* person, *now*. When the Generic and Idiomorphic seem largely congruent, there may be few problems. When they are not, which is frequently, the art, skill and judgement of the practitioner are more tested.

Dr R, over decades, had attempted to repair the damage done to many patients where the generic medical or psychiatric diagnosis was expounded and executed with such unchallenged authority that any personal perspective or meaning became completely displaced. This management-without-personal-understanding was rarely beneficial and often harmful: it added to the sufferer's sense of alienation, passivity and disempowerment. Such are the perils of overusing the Medical Model. Dr R now listens to Dr S's plans for increasing the hegemony of the Generic-Medical-Psychiatric phalanx, driving its 'authority' deeper into the human wilder-ness; a realm where more fluid and delicate understanding is required. He fears not just for the fate of his patients, but his own professional integrity.

Dr R speaks out and attempts to condense his notions and concerns with courtesy but conviction. Dr S is also courteous, but appears distracted, bemused and uncomprehending. While Dr R wonders whether this is a cannily disingenuous ploy,

he looks around at his colleagues. Some are looking towards him, smiling tentative encouragement. Others gaze down and away, averse to any possible discordance, especially with authority. The remainder remain immobile and impassive: bystanders. Dr S urbanely moves the meeting on: 'Any other questions?'

As the proceedings close, several delegates approach Dr R, to offer nervous support and confederation. One is Dr T, a formally dressed, middle aged, softly spoken man. He looks over his shoulder and says, with a quietness bespeaking conspiracy: 'I'm really pleased you said all that ... I don't think I'd have the courage, even if I could find the words'.

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Forty years ago Dr R read a, then seminal, book by a maverick, elderly Hungarian psychoanalyst, Michael Balint. It was titled 'The Doctor, his Patient, and the Illness', and enriched the working lives and relationships of hundreds of General Practitioners, for a generation. Balint met regularly, for many years, with a small group of GPs, building up portraits and understandings of the personal and interpersonal subtext of their medical practice: the unexpressed or hidden world of feelings, impulses or thoughts that lay behind the diagnoses, procedures and technical utterances – the generic. This type of *qualitative* research was never officially sanctioned or funded. It has been long supplanted by *quantitative* studies, conditionally financed and committee-endorsed. But Balint's informal research path had powerful cultural and educational effects: by freeing doctors to explore the idiomorphic, Balint enabled these practitioners to find new types of meaning and understanding in their encounters with the distressed and disrupted. They found themselves more able to heal, as well as treat: most reported much deeper work satisfactions. Such were Dr R's early mentors.

But Balint's influence was in a time of unwrapping: a time of adulterated disciplines and feral philosophy: an era whose health practitioners were often insighted and incited by such creative deconstructionists as Laing, Szasz and Illich.

There are now no such luminaries to excite professional human curiosity: professional motivation is now engineered by a financially induced system of NICE

guidelines, QOF points, goals and targets, and an endless rash of algorithms. Dr R is now struggling to find intellectual oxygen and human sustenance in this period of near-ubiquitous tight wrapping and containerisation. It is not just his supermarket that standardises, unit-packs, film-wraps and bar-codes natural products for managed distribution. He is working for a healthcare service that intends to do the equivalent with much higher and more sentient life forms. He thinks of Cathy, Amir, Clare, Alf and Tom ...

How do we respond?

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'The young man knows the rules: the old man knows the exceptions.'

Portuguese proverb

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